Crime Victim Compensation Commission
Claims Application

For Office Use Only:

CVCC Case No.:_____

Crime Victim Compensation Commission
State of Hawaii, Department of Public Safety
333 Queen Street, Room 404, Honolulu, HI 96813
Telephone (808) 587-1143 / FAX No: (808) 587-1146

Type or Print in Black or Blue Ink. Provide as much information as possible

Home Telephone: _____

WorkTelephone:_____

Victim Information

Name _____
First Middle Last

Mailing Address _____
Street City State Zip Code

Date of Birth ___ ___ / ___ ___ / ___ ___ ___ ___ Social Security No. _____

• Male • Female Handicapped: • Yes • No • Married • Single **Check the one** you believe represents your ethnicity.

__ Black __ Chinese __ Filipino __ Hawaiian __ Portuguese __ Native American
__ Samoan __ Japanese __ Korean __ White __ Puerto Rican _____ Other

Applicant Information (Complete only if you are applying for the Victim who is a minor, deceased or incapacitated.)

Applicant's relationship to victim: _____ Home Telephone: _____

Work Telephone: _____

Name: _____
First Middle Last

Mailing Address _____
Street City State Zip Code

Crime Information

Type of Crime: (Murder, Assault, Sexual Assault, etc.) _____

Date _____ Location of Crime _____
Street City State Zip Code

Police Report No. _____ Name of Suspect _____
First Middle Last

Medical Information (Provide First and Last Name and Complete Mailing Address)

List the name(s) and the address(es) of the doctors and hospitals where the victim was treated below. In cases of death, provide the name of the mortuary and cemetery. Attach all bills, receipts and insurance statements. Provide the name of medical insurance and number: _____. (If you have no insurance, indicate "NONE".

Name of Provider	Address	Service Date	Total Charges
1.			
2.			
3.			
4.			

Victim Employment Information (Complete only if claiming for lost earnings.)

Did injury occur at work place? • Yes • No Did you miss work as a result of injury? • Yes • No

What was the period of absence? From _____ To _____
Month Day Year Month Day Year

Employer's Name _____ Telephone umber:_____

Mailing Address _____
Street City State Zip Code

Job Title _____ Rate of Pay _____ Gross Wage Loss _____

Insurance/Legal Information

How did you find out about the Commission? Circle most appropriate: Prosecutor's Victim Witness, Hospital/Medical Personnel, Law Enforcement (Police), Public Service Announcements, Newspapers.

Are you receiving assistance through the Victim Witness Office, Sex Abuse Treatment Center or Domestic Violence Coalition? If yes. Please provide the name of person helping you _____

Circle all potential sources of full or partial payment of expenses: Health Insurance, Automobile Insurance, Welfare, Medicare,

Medicaid, Social Security Disability, Workers' Compensation, Temporary Disability, Other, please specify: _____

_____
Name of Insurance Company Street City State Zip Code

Have you filed or do you intend to file a civil law suit? • Yes • No • Not Sure If yes, provide the following:

Attorney's Name _____ Telephone Number _____

Mailing Address _____
Street City State Zip Code

By the signing of this application:

- I certify that I have read this application.
- I have to the best of my knowledge provided information that is true and correct.
- I understand that the law provides for penalties for false statements that may increase the potential compensation.
- I must repay the commission should I receive moneys from civil suits, restitution or insurance payments.

_____
Signature of Victim Date

_____
Signature of Applicant Date

Check list before mailing:

Have you signed the application?
Have you provided us with your complete mailing address and telephone number?
Have you completed the information regarding the police report number, date and type of crime?
Have you submitted medical and/or funeral bills, receipts that you have in your possession?